

PATIENT LABEL

FORM \_\_\_\_ OF \_\_\_\_

**MEDICAL EXPENDITURE SURVEY  
MEDICAL PROVIDER COMPONENT**

**HOME CARE EVENT BOOKLET  
FOR NON-HEALTH CARE PROVIDERS**

**FOR**

**REFERENCE YEAR 2004**



- D1. During calendar year 2004, what was the (first/next) month during which your records show that services were provided in (PATIENT NAME)'s home?

MONTH: \_\_\_\_\_ YEAR: 2004

- D2. I need to know which type or types of persons provided services at (PATIENT NAME)'s home during (MONTH) and either the number of hours or the number of visits for each type.

EXPLAIN IF NECESSARY: By type of person I mean a housekeeper, therapist, nurse aide, yard worker, and so forth.

OFFICE USE ONLY	TYPE OF PERSON	HOURS/MINUTES:	VISITS:	
<input type="checkbox"/>	_____	____ / ____	OR ____	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/>	_____	____ / ____	OR ____	OFFICE
<input type="checkbox"/>	_____	____ / ____	OR ____	USE
<input type="checkbox"/>	_____	____ / ____	OR ____	ONLY

<input type="checkbox"/>	_____	____ / ____	OR ____
<input type="checkbox"/>	_____	____ / ____	OR ____
<input type="checkbox"/>	_____	____ / ____	OR ____
<input type="checkbox"/>	_____	____ / ____	OR ____

- D3. I need a description of the services provided during (MONTH).

	YES	NO
CLEANING OR YARD WORK .....	1	2
TRANSPORTATION .....	1	2
SHOPPING.....	1	2
EMOTIONAL SUPPORT PERSON OR ONE-ON-ONE BUDDY .....	1	2
SUPPORT GROUPS.....	1	2
CHILD CARE.....	1	2
OTHER (SPECIFY): .....	1	2

C2. What were the charges for the services provided to (PATIENT NAME) during (MONTH)?

**TOTAL CHARGES:** \$ \_\_\_\_\_.

C3. NOT ASKED THIS VERSION

| 1 |

OFFICE USE  
ONLY

C4a. Who paid your organization for the charges during (MONTH)?

a. Patient or patient's family \$ \_\_\_\_\_.

b. Medicare \$ \_\_\_\_\_.

c. Medicaid \$ \_\_\_\_\_.

d. Private Insurance \$ \_\_\_\_\_.

e. VA \$ \_\_\_\_\_.

f. TRICARE/CHAMPVA/  
CHAMPUS \$ \_\_\_\_\_.

g. Worker's Comp \$ \_\_\_\_\_.

h. OTHER (SPECIFY):  
\_\_\_\_\_ \$ \_\_\_\_\_.

C4b. ASK FOR EACH SOURCE OF PAYMENT  
MENTIONED: How much did (SOURCE OF  
PAYMENT) pay?

IF NAME OF INSURER OR HMO, PROBE: And is  
that Medicare, Medicaid, or private insurance?

C5. IF NOT VOLUNTEERED, ASK: And what was the total  
of all payments received for (MONTH)?  
[IF NOT AVAILABLE, COMPUTE.]

**TOTAL PAYMENTS:** \$ \_\_\_\_\_.

**BOX 1**

**DO TOTAL PAYMENTS (C5) EQUAL TOTAL CHARGES (C2)?**

YES ..... 1 (D4)

NO ..... 2 (C6)

C6. It appears that the total payments were (less than/more than) the total charges. What is the reason for that difference? [CODE 1 (YES) FOR ALL REASONS MENTIONED.]

**PAYMENTS LESS THAN CHARGES:** YES NO

**Adjustment or discount**

- a. Medicare limit or adjustment..... 1 2
- b. Medicaid limit or adjustment..... 1 2
- c. Contractual arrangement with insurer or managed care organization..... 1 2
- d. Courtesy discount..... 1 2
- e. Insurance write-off ..... 1 2
- f. Worker's Comp limit or adjustment..... 1 2
- g. Eligible veteran ..... 1 2
- h. Other (Specify:) \_\_\_\_\_ 1 2

**Expecting additional payment**

- i. Patient or Patient's Family..... 1 2
- j. Medicare ..... 1 2
- k. Medicaid..... 1 2
- l. Private Insurance..... 1 2
- m. VA..... 1 2
- n. TRICARE/CHAMPVA/CHAMPUS..... 1 2
- o. WORKER'S COMP ..... 1 2
- p. Other (Specify:) \_\_\_\_\_ 1 2
- q. **Charity care or sliding scale**..... 1 2
- r. **Bad debt**..... 1 2

**PAYMENTS MORE THAN CHARGES:**

- s. Medicare adjustment..... 1 2
- t. Medicaid adjustment ..... 1 2
- u. Private insurance adjustment..... 1 2
- v. Other (Specify):..... 1 2

D4. Have we covered all of the months your organization provided services to (PATIENT NAME) during the calendar year 2004?

YES, ALL MONTHS COVERED..... 1 (D5)

NO, NEED TO COVER

ADDITIONAL MONTH(S) ..... 2 (D1-NEXT  
EVENT FORM)

D5. REVIEW NUMBER OF MONTHS OF HOME CARE SERVICE REPORTED BY HOUSEHOLD. IF FEWER MONTHS OF SERVICE ARE REPORTED BY THE HOME CARE ORGANIZATION, PROBE TO EXPLAIN THE DIFFERENCE.

NO DIFFERENCE OR PROVIDER  
REPORTED MORE MONTHS OF  
HOME CARE SERVICE THAN  
HOUSEHOLD ..... 1 (D6)

PROVIDER RECORDED FEWER  
VISITS:..... 2  
PROBE: (PATIENT NAME) reported  
(NUMBER) months of home care  
service. Do you have any information  
in your records that would explain this  
discrepancy?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

D6. GO TO NEXT PATIENT FOR THIS PROVIDER.  
IF NO MORE PATIENTS, THANK THE RESPONDENT AND END THE CALL.